Parturient Perineorrhaphy

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• *In the light of improved means of combating infection, better and safer anesthesia, the ready availability of blood transfusion, and less traumatic delivery, reasons formerly advanced in opposition to operations at the time of parturition for repair of preexisting lesions of the pelvic floor are now less formidable than they were in the past.*

Such operations now can be carried out quickly and safely with considerable benefit in terms of immediate comfort and well-being of the patient, prevention of later development of more serious lesions, and savings in cost of hospitalization.

In a series of more than 300 patients so operated upon—the technique used is described herein—none died, and in a review of the records many advantages of operation immediately after delivery, as compared with long delay of needed repair, were noted.

FOR MANY YEARS it has been rather well accepted medical practice to advise women of childbearing age who are in need of repair of the pelvic floor to wait until they are beyond the reproductive years; and many gynecologists have been particularly averse to carrying out operations for correction of chronic lesions, caused by previous parturition, at the time of a subsequent delivery.

The principal reason advanced for long delay of such operations is the likelihood that if they are done in the childbearing years, succeeding parturition would but undo the repair. As to operations done immediately after childbirth for repair of chronic lesions, they have been considered hazardous because of increased risk of infection and the fact that sometimes the patient may have serious loss of blood. In recent years, however, what with antibiotics to combat infection, with transfusion a common procedure, with better and safer anesthesia, and with improved technique of delivery to lessen stresses and trauma that might disrupt the repair, these reasons have become less cogent.

Excellent repairs of lesions of the pelvic floor—notably relaxation and rectoceles—can be made immediately following delivery; and, now that injunctions against them are less firm than once they were, good medical and pecuniary reasons for carrying out the operation at that time come to the fore: The immediate well-being of the patient, prophylaxis against herniation of the rectum and the development of cystocele, and the saving in hospital cost effected by carrying out delivery and reparative operation concurrently.

In the past ten years the author performed perineorraphy at delivery in slightly more than 300 patients, none of whom died, and from a postoperative review the following lists of advantages and disadvantages were drawn:

Advantages:

1. Considering the usual complaints associated with relaxation of the pelvic floor, the well-being of the patient is served.
2. The correction of relaxation early is preventive of the development of more serious disease.
3. There is much less postoperative pain with parturient perineorrhaphy than there is when the operation is done at any other time.
4. There is less formation of actual scar tissue.
5. Healing in the postparturient period is much faster and more satisfactory than at any other time. (The average duration of postoperative hospital convalescence was four days.)
6. There is pronounced saving to the patient in time and money by virtue of avoidance of future hospitalization and prolonged convalescence.
7. Coitus is usually more satisfactory.

Disadvantages:

1. There may be an increased loss of blood.
2. Depending on technique, the potential of increased infection is present.
3. There is greater demand on the obstetrician's time.

The technique used by the author is simply a modification of the usual perineorrhaphy, except that sharp dissection is used throughout, rather than combined blunt and sharp dissection, because the tissues at the time of parturition are too friable to stand the usual traction and the lines of cleavage are too difficult to ascertain.

Even though spontaneous delivery might be easy,

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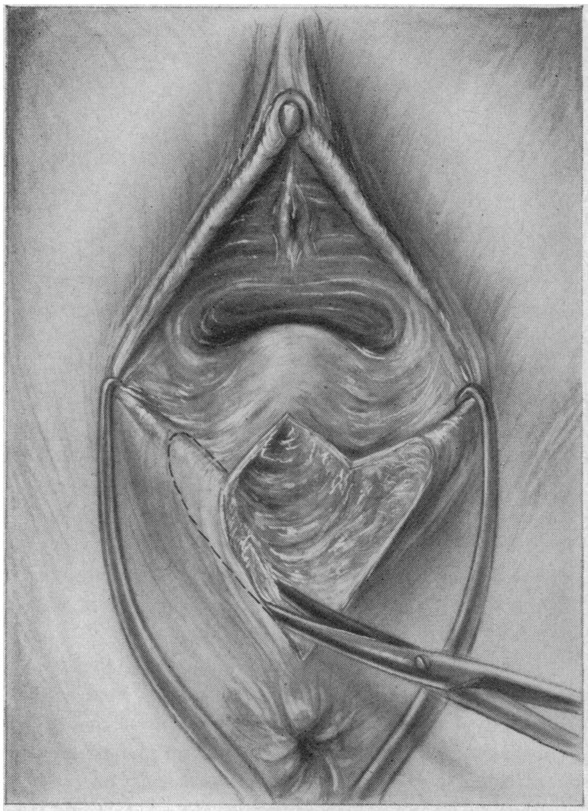

Figure 1

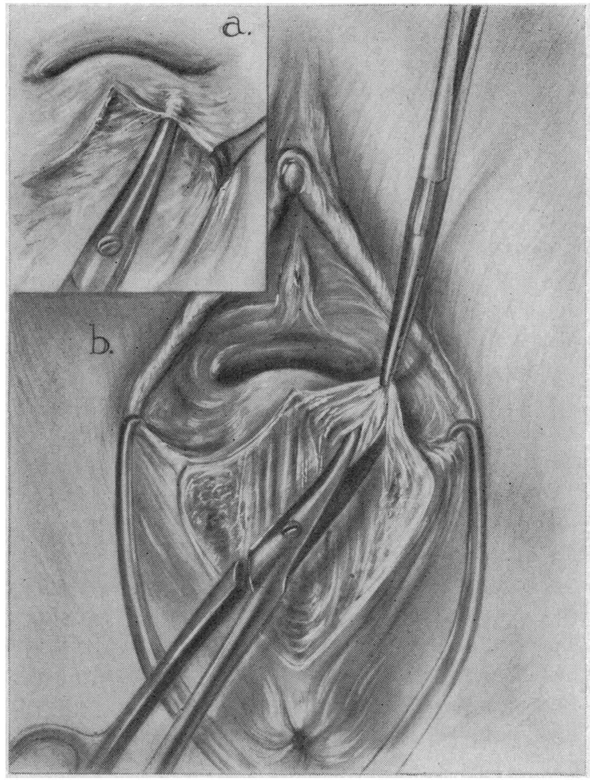

Figure 2

it is advisable to do midline episiotomy as the infant emerges. Following delivery of the baby, the placenta should be delivered by the most rapid method with which the accoucheur is familiar.

A Gelpi retractor then is placed with the points just above the last hymeneal caruncula (Figure 1). Old scar tissue, usually present at the mucocutaneous junction, is excised with curved scissors to the midline incision.

This done, dissection of the posterior wall of the vagina, with sharp instruments only, is begun. Curved scissors are used, with the points kept just underneath the vaginal mucosa (Figure 2a), so that there is no attendant risk to the rectum. The larger blood vessels are also avoided. Dissection is carried upward to the apices of the rectocele and laterally as far as necessary to expose the levator ani muscle. It is advisable to undermine the vaginal mucosa well laterally down to the introitus. The redundant lateral mucosa necessary to a satisfactory plastic closure is then resected, leaving an exposed triangle of muscle and fascia.

By placing the vaginal mucosal sutures and those of the levator ani one at a time and alternately, working room is preserved at both suture lines (Figure 3). The sutures can be continuous or interrupted and suturing is continued to the introitus,

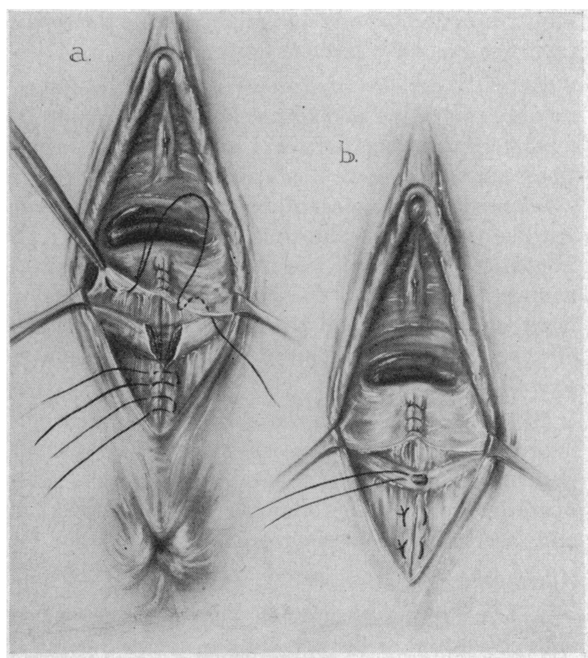

Figure 3

including the superficial and deep perineal muscles. Particular care must be taken in placing the deep sutures of the levator ani, for if they are extended too far laterally, a ridge that will result in later dyspareunia will be produced.

Final closure (Figure 4) is begun with a continuous No. 00 chromic suture. A small curved needle is introduced upward underneath the skin of the labia. This is done on both sides, catching the bulbocavernosus muscles, and the sutures are tied in the midline. One end of the suture is left long, and suturing with the long end is then continued downward in the midline to the lower angle of the incision. From there the suture is returned subcutaneously to the original point and tied subcutaneously, burying the external suture completely. The entire procedure should not take more than 15 minutes for a surgeon familiar with the technique.

It is most important in the immediate postoperative period to be alert for indication that the patient may have lost blood in unsuspected amount. (The amount of blood lost even in simple episiotomy, when carefully measured, is usually a surprise to the surgeon.) The hemoglobin value must be checked the day following operation and, when necessary, blood transfusion administered. In parturient perineorrhaphy the technique must be fairly rapid in order that loss of blood be kept to a minimum.

DISCUSSION

Neither infection nor postoperative pain was a problem in the present series. There was no more discomfort than that associated with midline episiotomy.

Hematomas occurred no more often than they do in connection with episiotomy. In the present series they were less common than they are in mesiolateral episiotomy, probably owing to the better exposure of bleeding vessels.

Particularly to be guarded against in perineorrhaphy is too tight a repair, lest dyspareunia result.

At first the author did parturient perineorrhaphy only in cases in which there was well developed rectocele without cystocele, but now is of the opinion that repair sufficient to provide a good supporting perineum should be done in all cases in which there is relaxation of the pelvic floor. Even where the relaxation is so extreme as to necessitate further operation later for correction of descensus uteri or cystocele, perineorrhaphy gives a great deal of immediate relief and prevents further accentuation of the more severe condition until such time as the more extensive procedures can be satisfactorily carried out. At the time of the later operation, the fact that perineorrhaphy has already been done adds no complication except that of a midline incision for exposure. Perineorrhaphy need not be repeated at the time of the second operation.

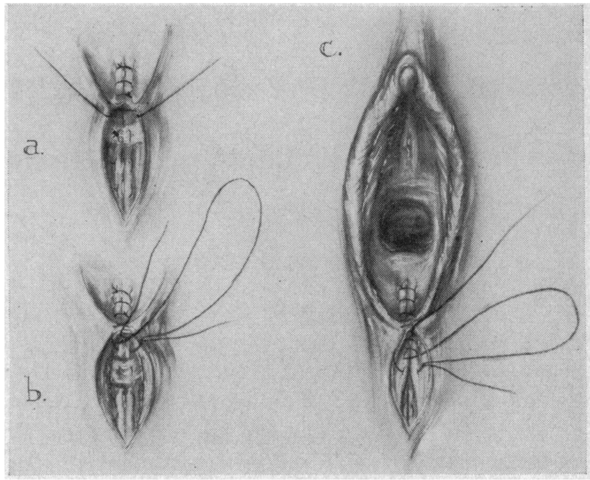

Figure 4

It is not a particular technique for operation that is advocated (for the technique is relatively unimportant), but the principle of repair at the time of parturition. The operation can be done quickly, easily and safely by competent surgeons.

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